800 PLAN DEVELOPMENT

801 Overview

This chapter provides information regarding the process for developing and revising the Individual Support Plan (ISP) for individuals served by DES/DDD. It describes the various types of plans, outlines the content requirements for each type of plan, and specifies the responsibilities of the Support Coordinator and other team members for developing and revising the ISP. It also explains the process for conducting team meetings and for resolving differences of opinion regarding plan content.

802 Definition

The ISP is a written statement, developed by an interdisciplinary team (ISP team), of needed services to be provided and goals to be attained for a person with developmental disabilities. The ISP directs the provision of safe, secure, and dependable active treatment in areas that are necessary for individuals to achieve full social inclusion, independence, and personal and economic well-being.

A.R.S. § 36-551
A.A.C. R6-6-603

803 Policy

It is a requirement that each person who has been determined eligible to receive services from DES/DDD must have an ISP, written on the forms specified in this chapter. The plan will be developed by an ISP team of appropriate persons to include, but not be limited to, the individual, his/her parent or guardian, if any, and the DES/DDD Support Coordinator. The initial ISP must be completed within 30 days of determination of eligibility for DES/DDD services. Once the individual is assigned to a specific service operated or financially supported by DES/DDD, an annual ISP must be completed within 30 days unless waived in accordance with the procedures specified in Section 808.2 of this Chapter. The ISP shall be reviewed at least at six month intervals thereafter, and more often if necessary, to ensure that the plan remains appropriate and that the person is making progress toward the goals and outcomes specified in the plan. (See Chapter 1000 of this manual). The ISP team shall meet at least annually to review and revise the plan and more often, as specified in this chapter, whenever there is a significant change in the person's status.

A.R.S. § 36-551.01; §36-565
A.A.C. R6-6-604

804 Operating Principles

The ISP must be in the best interests of the person served, that is, the plan must be centered upon the strengths, resources and needs of the individual served, not upon the needs of DES/DDD or its contracted providers. The interests of the responsible person and/or the individual's family must also be considered, when appropriate.

The plan must be based upon formal and informal evaluations and assessments, the preferences of the individual and/or family/responsible person, and a written statement of the person's goals and desired future. Needs, outcomes, and services identified in the plan must be designed to allow the person to meet his/her goals and function as independently and successfully as possible.

The plan must be cost-effective, addressing and utilizing resources and supports available within the person's family, neighborhood and community. Services funded by DES/DDD will be considered only when other resources and supports are insufficient or unavailable and do not meet the needs of the individual/family that are attributable to the person's disability.

In designing the plan, the ISP team must consider the unique characteristics and needs of the individual/family as expressed by the individual/family and others who know the person. Consideration must be given to the likelihood that the goals, outcomes, services and agreements identified in the plan will:

a. protect the rights and promote the independence, competence and dignity of the person served;

b. allow for maximum social inclusion;

c. preserve the integrity of the individual/family;

d. prevent the deterioration of family structure and functioning;

e. improve quality of life;

f. prevent or alleviate abuse or neglect; or

g. eliminate conditions that hinder the person's development.

DES/DDD employees and contracted providers must include the individual and family in problem-solving and decision-making and ensure that services are provided in an unintrusive manner.

The ISP team functions as an interdisciplinary team. An interdisciplinary team is one in which persons of various backgrounds interact and work together to develop one whole, integrated plan for the individual/family. An interdisciplinary process encourages mutual sharing of the strengths and insights of all team members, including the individual/family, rather than reliance on professionals who concentrate on a specific discipline. Team members are encouraged to participate in discussions related not only to their primary area of expertise but to all aspects of the person's life.

A.R.S. § 36-551.01
A.A.C. R6-6-602

805 Team Membership

The membership of the team will vary depending upon the needs and wishes of the individual and/or family.

The ISP team will include, but not be limited to, the individual; the individual's parent or guardian, if any; the DES/DDD Support Coordinator, who shall serve as plan facilitator and coordinator; representatives of any service being provided or indicated by assessment to be needed; and any additional person(s), approved by the individual/responsible person, whose participation is necessary to develop a complete and effective plan.

Occasionally, there may be a need for non-participating persons, such as staff in training or observers from monitoring groups, to be present at team meetings. Since these persons are not team members, the DES/DDD Support Coordinator shall seek prior approval for their presence from the individual/responsible person.

A.R.S. § 36.551.01
A.A.C. R6-6-101

Additional team membership requirements for each service setting are indicated below.

805.1 Home and Community Based Settings (HCBS)

ISP teams for persons served in HCBS settings must meet the minimum team membership requirements specified above.

805.2 Residential or Day Program Settings

For persons served by a residential or day program operated or financially supported by DES/DDD, the ISP team will include, in addition to those persons listed above, individuals who work directly with the person served. This shall not be construed to mean staff whose primary responsibility is supervision or administration of residential or day program settings.

805.3 Persons who are Medically Involved

Team membership for those individuals who are determined by DES/DDD Managed Care Operations (MCO) to be medically involved will include, in addition to those persons listed above, a person qualified to address the health and medical needs of the individual, such as a nurse. MCO will determine which DES/DDD staff or providers meet this qualification and notify the Support Coordinator of the assigned team member.

805.4 Intermediate Care Facilities for the Cognitive Disabled (ICF/MR)

For persons residing in an ICF/MR, the ISP team must include, in addition to all persons listed above, a qualified cognitive disability professional (QMRP), who typically is the DES/DDD Support Coordinator; the individual's primary care physician (PCP) who may provide input by means of written reports, evaluations, and recommendations; the nurse assigned to the facility; therapists in those therapy services where there is an indication of need and/or where services are currently being provided; and providers of direct service in other programs received or needed by the individual, such as adult day, child day, or educational programs.

805.5 Nursing Facilities (NF)

Team membership for individuals receiving services in a NF will include, but not be limited to, the individual; the individual's responsible person; the DES/DDD Support Coordinator; the individual's PCP; therapists in those therapy services where there is an indication of need for service and/or where services are currently provided; and the individual's primary care giver(s).

806 Team Meetings

806.1 Frequency of Meetings

The ISP team must meet within 30 days of determination of eligibility for DES/DDD to complete the initial ISP for the individual. Unless waived as specified in Section 808.2, the team will meet again within 30 days following assignment to a program, i.e., residential setting, day program or early intervention program, or service to review and modify the initial ISP; this becomes the Annual ISP for the individual. The ISP team must subsequently meet at least annually and whenever there are changes in the individual's circumstances which require a significant change in the plan (see Section 808.5 of this Chapter).

The Support Coordinator shall review the ISP and update the Service Plan screen in ASSISTS within 10 days of notification to DES/DDD of eligibility for ALTCS. This ISP review will consist of a face to face meeting with the individual/responsible person and may require a complete team meeting if significant changes in the ISP are required. If the individual is new to DES/DDD and/or an ISP is not in place, the Support Coordinator shall make contact with the individual/family within 5 days of notification to DES/DDD of eligibility for ALTCS. The Support Coordinator must provide a copy of the DES/DDD ALTCS Member Handbook to the individual/responsible person.

806.2 Notice of Meetings

The DES/DDD Support Coordinator shall notify ISP team members in writing of team meetings. This notification shall include the purpose of the meeting; be in each team member's primary language and/or primary mode of communication; be delivered at least ten (10) working days in advance of the meeting, except in emergencies; include the time, date, and place of the meeting; and include the means by which team members may indicate their intention to be present at, or absent from, the team meeting.

806.3 Meeting Process

The DES/DDD Support Coordinator shall coordinate the ISP team meeting, unless the individual/responsible person designates another person to coordinate the meeting.

The Support Coordinator shall ensure all team members are introduced and that the purpose of the meeting is explained. The Support Coordinator shall explain that the team will operate as an interdisciplinary team and that every effort will be made to reach

consensus, but that in the event consensus cannot be achieved, the appeal process may be initiated by any disagreeing team member. (See Chapter 2200). An explanation of the mediation program and the grievance and appeals process will be provided to the individual/responsible person by the Support Coordinator.

The Support Coordinator shall ensure that the person served and his/her family are treated with respect and dignity during the meeting, e.g., that comments are directed to the individual in first person rather than third person language; that sensitive issues such as the person's health or behavior are discussed with the same considerations that would be given to a nondisabled person, etc. The Support Coordinator shall also ensure that all participants are given an opportunity to provide input and that issues are thoroughly discussed before decisions are reached. Decisions shall be guided by DES/DDD's Mission and Value Statement (Section 202) and the ISP Operating Principles (Section 804).

The standard agenda for a meeting shall consist of:

a. review of the last ISP;

b. review of professional evaluations and assessments, as needed;

c. discussion of the person's current status (strengths/needs list), preferences, and desired future environment;

d. development of long term goal(s);

e. development of outcomes which when attained will lead to the long term goal(s);

f. discussion of services needed to attain the long term goal(s) and outcomes;

g. discussion of other actions necessary to implement the services, achieve the outcomes and long term goal(s), and meet the individual's needs; and

h. discussion of other special considerations, such as spending plan, residential licensing requirements, etc.

When special circumstances require a different agenda, the Support Coordinator shall communicate the revised agenda to the team at the beginning of the meeting.

807 Components of the Plan

The content of an ISP will vary depending upon the purpose of the team meeting, the unique characteristics of each person served, and the person's service setting. Major components common to all individuals are outlined below.

807.1 Review of Last ISP

Except for Initial ISPs, each ISP shall document review of the prior ISP. The review shall contain a description of major accomplishments and the status of each outcome, service, and team agreement. The purpose of this review is to ensure that the current ISP is not written in isolation but builds upon and updates the prior ISP.

807.2 Assessments/Evaluations and Development of Functional Statements of Need

ISPs shall be based upon a team synthesis and summary of the results of formal and informal evaluations and assessments of the individual.

Formal evaluations are those completed by a team member or professional for a specific purpose or using a specific assessment tool. Examples of formal evaluations include the ICAP, the PAS, a physical exam, or a psychological evaluation.

The number and type of formal assessments needed to develop the ISP will vary depending upon the needs of the individual, the services provided, and the setting in which those services are provided.

For persons receiving services in a residential setting, the team shall review all available assessments and evaluations and address all recommendations unless such recommendations are too vague to indicate a programmatic direction, or the team chooses to defer addressing a specific recommendation until a later date. In all cases the team shall document the reason for not addressing a recommendation made in a professional evaluation or assessment.

Informal evaluations include the team's discussion of the person's strengths, needs, and preferences. For example, the Support Coordinator may know from interviewing the parent and observing and interacting with the individual during several home visits that the person is uncomfortable meeting new people and does not like to be in large groups. This information may not be documented in a formal evaluation, but is essential when planning goals, outcomes and services with the person.

In completing the review of formal and informal assessments and evaluations, the team shall identify and describe the strengths, limitations and concerns of the individual with attention to each of the following life domains:

a. Health and Physical Development - this domain includes fine and gross motor skills as well as general medical condition and history;

b. Cognitive Development - this domain includes the person's ability to process and use information, make judgments, and learn;

c. Communication Skills - this domain includes expressive and receptive language skills, including speech development and the need, if any, for assistive devices;

d. Psychosocial Skills - this domain includes the person's relationships with others, as well as the ability to cope with the environment and express emotional needs;

e. Self-Help Skills - this domain includes activities of daily living, including home management and personal living skills;

f. Family and Community Involvement and Supports - this domain includes the resources and supports necessary for the person to live successfully and participate fully as a member of his/her family, neighborhood, and community;

g. Educational and/or Vocational Skills - this domain addresses the skills necessary for the person to participate fully at school and at work; and

h. Guardianship Status and Current Placement - this domain addresses an individual's legal status and current living arrangement.

The team shall identify and document, using the results of the formal and informal assessments described above, areas that the individual/family wants to change or strengthen. Needs statements shall be functional statements, oriented to the overall outcome envisioned for and by the individual and developed with consideration of the person's strengths and preferences.

As part of the assessment process, functional statements of need should be developed without regard to available services or funding sources.

807.3 Long Term Goal

Each ISP shall contain a long term goal which answers the question "to what end are services being provided?" and is the ISP team's description of where the individual will live and what the individual will do at the end of the next 3 to 5 years. The long term goal shall reflect the individual/family strengths, preferences and desired future environment, and shall be developed without regard to the availability of services or funding sources. Long term goals do not typically change except to reflect major life transitions or significant changes in the person's status.

807.4 Implementation of Goal

Each ISP shall contain a description of the outcomes, services, and other supports that will be provided to attain the long term goal.

807.4.1 Outcomes

Outcomes shall be written to address those needs identified as priority which require attainment of skills in order to meet the long term goal. All ISPs for individuals who receive Habilitation, Day Treatment and Training, Employment Related Programs, Occupational Therapy, Speech Therapy, or Physical Therapy shall contain outcomes developed by the ISP team at the time of the planning meeting. Outcomes shall be realistic, developmentally sequenced, observable, measurable and time-limited.

Each outcome shall include a statement of the observable, measurable behavior the individual will exhibit, the conditions under which the behavior will occur, the criteria by which the team will determine that the skill has been acquired and the date by which the team reasonably expects the skill to be acquired.

A teaching plan or strategy shall be written for each outcome describing the methodology that will be used to teach the individual the skills necessary to achieve the outcome. The teaching plan/strategy shall detail how, when, and by whom outcomes will be implemented, the method to be used to record data relative to program progress, and the procedure that will be followed should progress not be made as envisioned.

807.4.2 Service Plan

Following development of the functional statements of need, the long term goal(s), and the outcomes, the ISP team will identify the resources/supports necessary to accomplish the goal(s) and outcomes. The team shall first consider and document those resources, services, and supports which are available within the family, neighborhood and community and use this information to identify the necessary and appropriate services that are recommended to be provided by DES/DDD.

The Service Plan section of the ISP must list the name of the service, the ASSISTS code for the service, the number of units of service to be provided and the frequency with which it is to be provided, the name of the provider(s) who will deliver the service, the projected start date of the service, whether or not the service is on-demand or indirect, and whether the person will be on a waiting list for the service. For those individuals utilizing voucher authorizations, the individual/family will select the provider and schedule the service.

On-demand services are those services, such as respite, which are provided on an irregular schedule when the individual has an intermittent need. Indirect services are services provided by another agency, such as physical therapy provided by a public school.

The number of units of a service to be provided will be derived from consideration of the specific needs to be addressed by the service and the amount of time it takes to complete each task.

807.4.3 Team Agreements and Assignments

Each ISP shall document the additional activities to be completed and supports to be provided to meet the individual's needs and achieve the long term goal(s) and outcomes.

Examples include evaluations to be obtained or updated, referrals necessary for the person to receive needed services within or outside the agency, responsibilities to be completed by the individual/responsible person, and the name of the team member responsible for monitoring the behavior treatment plan.

Services such as Attendant Care, Home Nursing, Respite, Housekeeping, and Home Health Aide do not require outcomes and teaching plans/strategies; however, they may require detailed plans of care. Responsibility for completion and submission of these plans of care must also be identified in the Team Agreements and Assignments section of the ISP.

807.5 Other Issues to Be Addressed

As appropriate, the ISP shall address and document considerations, such as:

a. statements of barriers which identify a lack of resources available to meet an individual's need (see Waiting List procedures, Section 906);

b. identification of mechanical supports, if needed to achieve proper body position, balance or alignment. The plan must specify the reason for each support, the situation in which each is to be applied, and the schedule for each support;

c. for persons served in a residential setting or for whom DES/DDD or a Public or Private Fiduciary is

Representative Payee for benefits, a Spending Plan which indicates how the person's financial resources will be used;

d. exceptions to programmatic and contractual requirements;

e. opportunities for individual choice and self management, including quality of life issues such as opportunities to participate in community activities and the development of relationships with members of the community who are not paid to be with the individual;

f. for persons residing in an ICF/MR, results of a comprehensive professional interdisciplinary review of the individual's physical, emotional, social, and cognitive factors which indicate the need for placement, or continued placement, in an ICF/MR;

g. for persons residing in an ICF/MR, if the individual does not possess the personal skills essential for privacy, such as toileting, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic wants and needs, there shall be ISP outcomes which specify a regular, systematic, training program unless it has been documented by the team that the individual is developmentally incapable of acquiring the skills;

h. for persons residing in a NF, the ISP shall include a medical evaluation by a physician indicating the individual's need for care in a NF. The evaluation shall include diagnosis, summary of present medical findings, medical history, mental and physical functional capacity, prognoses, and a recommendation concerning either admission to or continued placement in the NF. Recommendations contained in the PASARR Level II evaluation must be considered and the ISP must include a

discharge plan which describes post institutional plans as well as a long term placement goal;

i. for persons receiving care for their personal needs, the individual has the opportunity to choose the gender of the person providing care; and

j. documentation of the presence or absence of an Advance Directive (See Section 1504 of this Manual).

808 Documentation Requirements for each Type of Plan

ISPs must be documented on the forms and in the manner specified in this chapter. Requirements for each type of plan are outlined below.

808.1 Initial ISP

The purpose of the placement evaluation, known as the initial ISP, is to review the results of all previous evaluations, and the medical and program history of the individual in order to recommend assignment to programs or services operated or supported by DES/DDD.

The initial ISP may consist of the following documents:

ISP Cover Sheet (DD-214, Appendix 800.A);

Team Assessment Summary (DD-217, Appendix 800.B);

Preferences and Vision of the Future (DD-218, Appendix 800.C) - This form must be used with sensitivity to the needs of the individual served. It is not appropriate for persons who are terminally ill and may not be appropriate for very young children when the parents are still adjusting to their child's disability;

Long Term Goal and Implementation of Goal (DD-219, Appendix 800.D); and

Summary of Professional Evaluations (DD-216, Appendix 800.E) - this form should also be used when the Team Assessment Summary does not adequately summarize the results of the formal evaluations the person has received, such as when the person is medically involved.

A.R.S. § 36-560(G)(H)
A.A.C. R6-6-602

808.2 Annual ISP

The purpose of the Annual ISP is to review the initial or subsequent ISP and develop additional or more detailed outcomes and methods for achieving the goal(s) specified in the ISP.

The Annual ISP may contain the following documents:

ISP Cover Sheet (DD-214, Appendix 800.A);

Review and Update of Last ISP (DD-215, Appendix 800.F);

Team Assessment Summary (DD-217, Appendix 800.B);

Preferences and Vision of the Future (DD-218, Appendix 800.C) (See above note in 808.1);

Long Term Goal/Implementation of Goal (DD-219, Appendix 800.D); and

Teaching Plans/Strategies for Achieving Objectives.

For individuals served in residential settings operated or financially supported by DES/DDD, the Annual ISP shall also contain the Summary of Professional Evaluations (DD-216, Appendix 800.E).

For individuals served in residential settings operated or financially supported by DES/DDD, the Annual ISP shall also contain Support Information (DD-220, Appendix 800.G) and an Individual Spending Plan (DD-221, Appendix 800.H).

For individuals receiving behavior modifying medications or otherwise requiring a behavior treatment plan, the ISP shall include all components of a behavior treatment plan as specified in Chapter 1600.

The ISP meeting required within 30 days of placement in a service operated or financially supported by DES/DDD may be waived if all of the following conditions have been met:

a. the initial ISP was completed within six months prior to placement in a service operated or financially supported by DES/DDD;

b. approval of the individual/responsible person is obtained;

c. the Support Coordinator has reviewed the Initial ISP to ensure that it remains current and meets all requirements of an Annual ISP, as outlined in Section 808.2;

d. all providers of services operated or financially supported by DES/DDD have received and reviewed the initial ISP

and agree that they can provide services based upon that plan; and

d. the individual can safely and effectively receive services without a face to face meeting of the team, as determined by the Support Coordinator in consultation with the individual/responsible person and service providers.

The Annual ISP cannot be waived for persons placed in a residential setting. The DES/DDD Support Coordinator shall ensure that justification for waiving an Annual ISP is documented thoroughly in case notes of the individual's file.

808.3 ALTCS Service Plan

Upon notification via the ASSISTS roster that an individual is eligible for ALTCS services, the DES/DDD Support Coordinator must immediately review the most recent ISP. In the event an initial ISP has not been completed, is more than 6 months old, or does not thoroughly document the person's need for services, the DES/DDD Support Coordinator must contact the individual/responsible person by telephone within 5 working days and meet with the individual/responsible person and other relevant team members within 10 working days to complete or revise the initial ISP/Annual ISP.

The ISP forms have been designed to meet the requirements of the ALTCS Service Plan. For purposes of clarification, however, this section will describe specific ALTCS requirements for which DES/DDD is accountable.

Services provided under the ALTCS program must be "medically necessary" or medically related social or remedial services. Individuals who are eligible for ALTCS have been determined to be "at risk for institutionalization." Risk factors, as determined by AHCCCS, include the amount of supervision or assistance needed to complete Activities of Daily Living (toileting, bathing, dressing, grooming, eating, mobility, and transfer); Psychosocial Behavior (level of consciousness, judgment, orientation, disturbances of perception or thought, obsessive or compulsive behavior, social behavior, and wandering); the extent to which various therapies are needed, e.g., occupational, physical, rehabilitative nursing, individual/group counseling/psychotherapy, vocational therapy; continence of bowel and bladder; and level of sensory impairment (touch, hearing, communication, vision, and speech). Deficits in these areas can be interpreted as an indication of medical or remedial need.

AHCCCS requires that the process for development of an ISP for ALTCS Service Plan purposes must include an on site (in the person's home) assessment of individual needs, which includes the individual's medical/functional status, identification of the acute care physician, placement choices, family support, environmental needs, special needs,

e.g., durable medical equipment or evaluation by a home health nurse and existing services which may be provided through the community or family members. Based on the assessment of the individual's needs, the Support Coordinator should establish a plan of measurable goals which will ensure the ability to provide services allowing the individual to maintain or increase his/her functioning level. Support Coordinators must consider the cost effectiveness of service delivery, available resources and appropriateness of the service plan. (ALTCS Program Management Manual, Chapter 316.A.2) While ALTCS assigns these responsibilities to the Support Coordinator, DES/DDD expects the Support Coordinator to complete them in consultation with the ISP team as defined in this chapter.

The individual/responsible person must sign the ISP to document his/her involvement in its development initially and at least annually thereafter (ALTCS Program Management Manual, Chapter 323.3.F).

ALTCS covered services, as identified on the initial ISP or Annual ISP, must be implemented within 30 days of enrollment in ALTCS. In the event this cannot be accomplished, alternative services must be offered.

If the individual/responsible person cannot be reached by telephone to schedule the ISP within five working days of the date of ALTCS enrollment, the Support Coordinator will send a letter explaining the need for an in-person interview. The letter should instruct the individual/responsible person to contact the Support Coordinator immediately to schedule an appointment.

If the individual/responsible person cannot be reached by telephone and there is no response within five working days of the date the above referenced letter was sent, the Support Coordinator should make an on-site visit to the individual/responsible person's residence. If the individual/responsible person is not home, the Support Coordinator should attempt to determine his/her whereabouts, e.g., from relatives or neighbors, if possible so that the individual/responsible person can be contacted.

If the individual/responsible person still cannot be located, the Support Coordinator should leave a form letter at the residence requesting that he/she contact the Support Coordinator as soon as possible. If there is no contact within 30 days of the date of enrollment in ALTCS, the Support Coordinator will complete an ALTCS Member Change Form and send it to the local ALTCS Eligibility Office for potential disenrollment. In addition, the Support Coordinator must document thoroughly in the case notes all attempts to contact the individual/responsible person.

808.4 ISP Reviews

The ISP shall be reviewed by the Support Coordinator at intervals specified in Chapter 1000, Plan Monitoring, but at least every six months. Documentation of reviews shall be as specified in Chapter

1000, with the following exception: at least annually, the entire team shall conduct a face to face team meeting, as specified in Sections 804 through 807. Documentation of this meeting shall be as specified for Annual ISPs, Sections 808.2.

For individuals receiving Targeted Support Coordination, the individual/responsible person shall decide the frequency of the contact and this decision shall be documented in the ISP.

808.5 Special ISP

The ISP team must also meet to review and revise the ISP whenever changes in the individual's status require significant changes in the plan. The ISP team will meet in the following circumstances:

a. whenever there is a change in the individual's medical treatment or physical condition which significantly affects daily living and is not of a short term or emergency nature;

b. prior to any transfer from a residential setting operated or financially supported by DES/DDD, and whenever there is a major programmatic or service provider change which affects the continued implementation of the ISP;

c. whenever the results of a grievance/appeals process require a review and/or revision of the current ISP;

d. whenever an emergency measure, including use of behavior modifying medication, is used to manage a behavior two or more times in a 30 day period, or with any identifiable pattern; or when required by the results of Program Review Committee (PRC) or Human Rights Committee (HRC) reviews of behavior treatment plans (See Chapter 1600);

e. at the age of 2 1/2, to plan the Pre-School Transition, and whenever the Local Education Agency (LEA) recommends via their Individual Education Plan (IEP) process that a child should be placed in or discontinued from a residential placement for educational reasons. (See Section 912.4.1);

f. whenever requested by any team member, including the individual/responsible person. The Support Coordinator may suggest that the issue can be resolved without a team meeting, but shall schedule a meeting if such recommendation does not meet with the requesting team member's approval;

g. whenever the individual receiving services has not made progress on an ISP outcome within 6 months and other

attempts by the Support Coordinator to resolve the problem have not been effective; or

h. whenever a person who has been ALTCS eligible loses his/her ALTCS eligibility, in order to plan for how the person's needs can be met without this funding source.

Special ISP meetings shall be documented using an ISP Cover Sheet (DD-214, Appendix 800.A), a narrative explaining the reason for and results of the special meeting, and any other ISP forms applicable to the reason for the special meeting.

808.6 Plan Changes Not Requiring Team Meeting

Minor changes in the ISP may be recommended by any team member by completing and forwarding to the Support Coordinator a Change in ISP Outside Team Meeting Form (DD-224, Appendix 800.I). Examples of minor changes include changes in outcome criteria, changes in a home and community based service requested by the individual/responsible person during the Support Coordinator's home visit to monitor the ISP, implementation of occupational, speech, or physical therapy following completion of an occupational, speech, or physical therapy evaluation and necessary prior authorization, durable medical equipment ordered by the PCP or changes to a Spending Plan.

The Support Coordinator shall sign the Change in ISP Outside Team Meeting form signifying that the recommended change does not require a team meeting as outlined in Section 808.5, obtain the individual/responsible person's signature, file the original with the ISP in the individual's file and forward a copy of the form to each team member. Any team member who disagrees with the change may request a special team meeting (see 808.5).

809 Coordination with Other Plans

In addition to the initial and Annual ISP, other plans may be required if the individual served is a child receiving early intervention services, a school age child, a foster child, an individual receiving behavioral health services or is subject to Discharge Planning or Behavior Treatment Planning requirements (see Chapters 900, Section 911 and 1600 respectively).

809.1 Individual Family Service Plan

The Individual Family Service Plan (IFSP) is a written plan for providing early intervention services to children birth to age 3 and their families eligible for and participating in the Arizona Early Intervention Program

(AzEIP), a federally funded (Part C) program. The IFSP is developed jointly by the family and personnel involved in the provision of early intervention services. It is based on a multidisciplinary evaluation and assessment of the child, and on an assessment of the child's family if the family so desires. The IFSP includes the services necessary to enhance development of the child and the capacity of the family to meet the special needs of the child and identifies the agency or agencies responsible for delivery of identified services.

The Individual Family Service Plan (IFSP) shall be documented in accordance with Section 1404 of this Manual.

809.2 Individual Education Plan

The Individual Education Plan (IEP) is a plan developed by the local school district to guide their provision of special education services. Development of the ISP may be coordinated with the school district's development of an IEP. (See Chapter 900) The ISP may reference appropriate portions of the IEP, but the IEP cannot be substituted in total for DES/DDD's ISP.

A.R.S. § 36-555; § 36-560(G)(3)

At the ISP meeting the Support Coordinator will request the parent/guardian of a child of school age to sign an Authorization to Release Information (DD-524, Appendix 500.E) to allow the DES/DDD to obtain a copy of the IEP from the school. In addition, at the ISP meeting the Support Coordinator will request permission of the parent or guardian to release a copy of the ISP to the school. The Support Coordinator should document the wishes of the parent/guardian in the Team Agreement Section, Part C, of the Long Term Goal and Implementation (DD-219, Appendix 800.D).

809.3 Foster Care Case Plan

Development and review of the ISP must be coordinated with development and review of the Foster Care Case Plan. The Support Coordinator should make every effort to schedule ISP team meetings and foster care staffings concurrently. The Foster Care Case Plan, as outlined in Section 1401 and DES 5-53, will serve as an attachment to the ISP. The ISP may reference appropriate portions of the Foster Care Case Plan, but the Foster Care Case Plan cannot be substituted in total for DES/DDD's ISP.

809.4 Behavioral Health Service and Treatment Plan

Development and review of the ISP may be coordinated with development and review of the Behavioral Health Individual Service Plan. The ISP may reference appropriate portions of the Behavioral Health Individual Service Plan, but the Behavioral Health Individual Service Plan cannot substitute in total for DES/DDD's ISP.

809.5 Transfer Plan

Prior to transfer of a non-medically involved individual from a residential setting operated or financially supported by DES/DDD, the ISP team must meet to plan the transfer. The transfer plan will be documented on the Transfer Checklist (DD-223, Appendix 800.L) and the ISP Cover Sheet (DD-214, Appendix 800.A). See Chapter 900 for additional information.

809.6 Behavior Treatment Plan

The behavior treatment plan is not a plan separate from the ISP; it is a teaching plan/strategy for achieving an ISP outcome. Consequently, the ISP must document outcomes relevant to a behavior treatment plan as it would for any other identified need. The behavior treatment plan is then completed in compliance with Chapter 1600.

810 Responsibilities of Each ISP Team Member

810.1 Responsibilities of Support Coordinator/Plan Coordinator

The DES/DDD Support Coordinator, as plan coordinator, is responsible for the following tasks:

a. identifying team members and scheduling meetings of the interdisciplinary team;

b. notifying team members in writing of team meetings;

c. ensuring that copies of all current evaluations and assessments are available to the team members prior to the team meetings, if possible;

d. actively participating in team meetings;

e. coordinating meetings of the ISP team as outlined in Section 806.3, unless contrary to the wishes of the individual or his/her responsible person;

f. writing the ISP in clear and understandable language based upon consensus reached during the team meeting;

g. distributing copies of the completed ISP to all team members and service providers within 15 working days of the date of the ISP meeting and ensuring that copies of the ISP are available in all settings where the individual receives services;

h. ensuring that all data, including Service Plan and Waiting List information, is entered into ASSISTS;

i. ensuring that teaching plans/strategies written by service providers are consistent among service settings and comply with all rules, policies, and procedures of DES/DDD;

j. completing Cost Effectiveness Study Worksheet (DD-234, Appendix 600.D) and requesting Prior Authorization, if needed. (See Chapters 600 and 900);

k. monitoring and reviewing the ISP as outlined in Section 808.4 and Chapter 1000;

l. completing other assignments as determined by the ISP team;

m. ensuring that the individual/family receive services to meet medical/functional needs (within the availability of funds for State funded services); and

n. ensuring that the psychiatrist monitoring a Mental Health Individual Service Plan reviews, understands and agrees with any behavior treatment plan.

810.2 Responsibilities of the Individual/Family/Responsible Person

Areas of responsibility could include:

a. applying/re-applying for ALTCS;

b. being available to meet for required ISPs and reviews;

c. providing documentation for eligibility redetermination;

d. reporting issues with providers of service including potential/suspected fraud and abuse;

e. reporting changes of address;

f. reporting major changes in individual/family circumstances which may affect the provision of services;

g. signing appropriate consents;

h. providing appropriate receipts for Assistance to Families or Community Supported Living expenditures;

i. providing appropriate documentation to obtain requested assistance from DES/DDD;

j. providing other documentation as requested by DES/DDD, i.e., Third Party Liability information, burial insurance policies, etc.; and

k. complying with residential billing and cost of care requirements.

810.3 Responsibilities of Other ISP Team Members

Other ISP team members are responsible for the following tasks:

a. conducting, preparing and submitting assessments including recommendations and other information necessary to complete the ISP to the Support Coordinator at least 5 working days prior to the team meeting;

b. reviewing, prior to the team meeting, the individual's progress on the previous ISP and all currently available assessment and evaluation data;

c. requesting that the Support Coordinator invite other persons to participate as team members, if necessary;

d. actively participating in the team meeting and working cooperatively to achieve consensus in the spirit of the ISP operating principles;

e. writing plans of care or teaching plans/strategies necessary to implement assigned outcomes and submitting these to the DES/DDD Support Coordinator within 10 working days of the ISP meeting;

f. recording data relative to assigned outcomes;

g. submitting written reports summarizing progress toward assigned outcomes to the DES/DDD Support Coordinator by the 5th working day of each month. (Occupational,

Speech, and Physical Therapists shall submit progress reports to the Support Coordinator quarterly);

h. notifying the Support Coordinator and requesting a special team meeting be scheduled whenever there is a significant change in the individual's status as described in Section 808.5; and

i. completing other assignments as determined by the ISP team.

811 Procedures for Resolving Differences of Opinion Among ISP Team Members

The ISP team must seek to reach consensus in developing the ISP and in developing consistent and/or complementary strategies and methods for implementing the plan. Efforts should be made during ISP team meetings to ensure that all points of view are heard. Differences of opinion can usually be resolved by a thorough discussion of concerns and recommendations. If a team member feels that his or her point of view has not received a complete hearing during a team meeting, he/she is encouraged to discuss his/her concerns privately with the Support Coordinator, who will subsequently reconvene the team to readdress the issue. Such methods of informally resolving an issue are encouraged before mediation and formal grievance and appeal mechanisms are employed.

The individual and/or responsible person will approve the plan by signing the ISP Cover Sheet and indicating agreement. In the event he/she does not agree with the ISP, the procedures specified in Chapter 2200 should be followed.

In a situation where there may be disagreement between the individual and the family, the following guidelines should be followed:

a. if the individual is an adult 18 years of age or older and is his/her own responsible person, the wishes of the individual take precedence over those of the family;

b. if the individual is a minor child, the wishes of the family take precedence; and

c. if the individual is an adult who has been declared legally incapacitated and a guardian appointed, the wishes of the guardian take precedence over those of the individual and the family. In the case of limited guardianship, this guideline may not apply.

If team members agree that the plan is appropriate and should be implemented, they shall sign the ISP. If any team member disagrees with the plan, in whole or in part, that disagreement shall be indicated on

the ISP Cover Sheet and a formal appeal initiated in accordance with Chapter 2200. While an appeal is pending, the individual's previous ISP shall remain in effect for that portion of the plan in disagreement.